DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 1159 (03/01)

OTHER COVERAGE DISCREPANCY REPORT

Use this form to notify Wisconsin Medicaid of discrepancies between other coverage information obtained through the Eligibility Verification System (EVS) and information received from another source. Wisconsin Medicaid will verify the information you provide below and update the recipient file (if applicable). Attach any available documentation, such as Explanation of Benefits (EOB), indicating benefit coverage dates/denials or photocopies of current insurance cards. This will allow records to be updated more quickly. Type or print clearly.

① Date _____

② Provider Name _____ Medicaid Provider Number _____

③ Recipient Name _____ Medicaid ID Number _____

④ EVS indicates	⑤ Another source indicates
___ Medicare Part A Coverage	No Medicare Part A Coverage — end date _____
___ Medicare Part B Coverage	No Medicare Part B Coverage — end date _____
___ No Medicare Part A Coverage	Medicare Part A Coverage — HIC No. _____ start date _____
___ No Medicare Part B Coverage	Medicare Part B Coverage — HIC No. _____ start date _____
___ Commercial HMO	Recipient left HMO service area effective _____
___ Commercial HMO	No HMO Coverage — end date _____
___ Other Insurance Coverage	No Insurance Coverage — end date _____
___ No Insurance or HMO Coverage	Insurance or HMO Coverage — Insurance Name _____ Insurance Address _____ Recipient's Employer (if available) _____ Policy Number _____ Policyholder Name _____ Coverage Start Date _____ Coverage End Date _____

⑥ This form was completed by _____
(name of individual)
Phone Number (_____)_____ extension_____

⑦ Source of the information _____
(name of individual)
Phone Number (_____)_____ extension_____

MAIL TO Wisconsin Medicaid
Coordination of Benefits
6406 Bridge Road
Madison, WI 53784-6220

FAX TO Coordination of Benefits
(608) 221-4567